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A Revolution in White--New Approaches in Treating Nurses as Professionals

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A. *Introduction*

During the past few years physicians, consumers, and attorneys have become increasingly aware of the use of malpractice claims as a mechanism for regulating the quality of health care.[1] Concurrently, the escalating costs of providing medical care[2] have brought

1. *See, e.g.*, Curran & Moseley, *The Malpractice Experience of Health Maintenance Organizations*, 70 NW. L. REV. 69 (1975); King, *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213 (1975); *Symposium—Medical Malpractice*, 1975 DUKE L.J. 1 (1975).

2. *See, e.g.*, N.Y. Times, Dec. 23, 1976, at 42, col. 5; N.Y. Times, Nov. 22, 1976, § 1, at 20, col. 6; N.Y. Times, Aug. 28, 1976, at 1, col. 8.

pressure on the health care system to find and to provide low cost alternatives for the consumer. These two trends are related and, as increased use is made of non-physician providers of health care, courts will be forced to consider the appropriate standard of care that these non-physicians must meet. While some commentators have considered the problem of measuring standards of care,[3] legal literature is almost completely devoid of any in-depth consideration of nursing, the one significant profession that is most capable of expanding its role in providing non-physician health care.[4] This lack of knowledge has led courts to adopt a variety of confusing approaches to questions involving nurses' liability for malpractice.[5] This Note will review the development of nursing as a profession, discuss current trends in nursing, review the current case law in light of these developments, and, finally, propose alternative approaches to the questions relating to nursing malpractice. Specifically, this Note will examine the questions of the appropriate statute of limitations for nursing malpractice cases, the need for nurses as expert witnesses in malpractice actions, and the proper standard of care for a registered nurse. These questions will be considered in the context of the various state licensure laws, the newly established nurse certification programs, and the formal educational training of nurses.

B. Early History of Nursing

An awareness of the origin and development of nursing in this country aids in understanding why courts have failed to treat nursing as a profession. Tentative steps toward the recognition of nursing as a separate discipline were taken in the first half of the nineteenth century. In 1809 Elizabeth Seton founded the Sisters of Charity to give medical care to the poor, and in 1839 Dr. Joseph Warrington founded the first sectarian group to care for the ill.[6] He also instituted a short course to train future nurses in maternity

3. Kissam, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 KAN. L. REV. 1 (1975).

4. For a general discussion of traditional nursing malpractice case law, see Pavalon & Robin, *Damage Suits Based on Nursing Malpractice*, 57 ILL. B.J. 282 (1968); Note, *Hospital Nurses and Tort Liability*, 18 CLEV.-MAR. L. REV. 53 (1968). These articles, however, do not relate current changes in the nursing profession to possible changes in nursing malpractice laws.

5. Thus the California appellate court extended to nurses the malpractice statute of limitations while the Ohio Supreme Court did not. *Compare* Louie v. Chinese Hosp. Ass'n, 249 Cal. App. 2d 774, 57 Cal. Rptr. 906 (1967) *with* Richardson v. Doe, 176 Ohio St. 370, 199 N.E.2d 878 (1964).

6. L. FLANAGAN, ONE STRONG VOICE 10 (1976) [hereinafter cited as FLANAGAN].

care.[7] During the Civil War Dorothea Dix supervised a corps of army nurses.[8] Her statement of the qualifications necessary to become an army nurse indicates that nursing was still in its formative stages. To qualify as an army nurse, applicants had "to be 30 to 50 years of age; they [applicants] had to have good health and endurance; they had to have a matronly demeanor and good character; and they had to be plainly dressed."[9]

In the quarter century after the Civil War, nursing training became more formalized. This era was characterized by the development of schools of nursing and the initial effort to organize nurses in common organizations. In 1872 Women's Hospital of Philadelphia became the first endowed school of nursing in the United States.[10] The first nursing textbook was published in 1879, and by 1885 nursing textbooks were beginning to recognize that nursing care included more than simple obedience to physicians' orders.[11] Hospitals were the major training ground for nurses, making standardization of nursing care difficult to achieve. Nurses tended to identify with the institution that trained them rather than with the concept of belonging to an organized profession. Steps to remedy this lack of professional identification began in 1893 with the first national meeting of nurses[12] and the formation in 1896 of the first national organization of nurses.[13]

C. *The Licensure Movement*

Nursing, along with other groups aspiring to professional status at the end of the nineteenth century, viewed licensure as a means of acquiring control over membership in the emerging profession.[14] Nursing scholars have identified three major periods in nursing licensure. Chronologically the first period began in 1901 and extended to the mid-1930's. The second period began in 1936 and lasted until 1971. The third, and current, period began in 1971.[15]

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7. *Id.* at 11.
8. *Id.* at 13.
9. *Id.*
10. *Id.* at 16.
11. *Id.* at 17, 20. Interestingly, up to this point physicians had been in the forefront in pushing for improvements in the quality of nurse training. This early role of the medical community in the development and improvement of nursing had continuing influences later when nursing began to assert its autonomy. *See* note 65 *infra* and accompanying text.
12. FLANAGAN, *supra* note 6, at 27.
13. Shannon, *Our First Licensing Laws,* 75 AM. J. NURSING 1327 (1975).
14. *Id.* The constitutionality of state licensure laws was upheld in Dent v. West Virginia, 129 U.S. 114 (1888).
15. Bullough, *The Law and the Expanding Nursing Role,* 66 A.J. PUB. HEALTH 249 (1976).

In 1901 nurses formed state associations in Illinois, New Jersey, New York, North Carolina, and Virginia to lead the drive for state licensure, which was one of the major objectives of the newly established national nursing organizations. These efforts culminated in the passage of nursing licensure laws in four of the above states during a two month period in 1903,[16] but these early laws had four major weaknesses. First, they only regulated the use of the title "nurse." Individuals were free to continue to perform the same tasks they had performed before the enactment of licensure statutes as long as they did not claim nursing status. Secondly, in two of the four states the board of examiners was not composed exclusively of nurses.[17] Thirdly, the educational requirements for entry into the profession were minimal.[18] Finally, none of these original acts defined nursing in terms of the allowable scope of practice, but instead emphasized that nurses complete a regulated course of study and pass a state-administered examination.[19] By 1923 all states had similar nursing licensure acts. The weaknesses in these first licensure laws had a continuing impact on nursing. In 1938 nineteen states still did not require high school graduation for licensure, and seventeen states included at least one physician on their nursing boards.[20] This factual backdrop is relevant in evaluating early court decisions that refused to treat nurses as professionals. By appreciating the historical context of the early decisions, it is possible to limit those cases to their proper historical period.

During the second stage of licensing laws, from 1938 to 1971, the nursing profession stressed mandatory licensure[21] and, concomitantly, began developing a definition of nursing, which was necessary to regulate effectively the practice of nursing. In 1955 the American Nurses Association, the national professional organization for nurses, adopted the following definition of nursing practice:

16. *Id.* at 250. Since these laws were passed prior to the nineteenth amendment, it was necessary to find and use powerful allies. The New York experience indicates the successful implementation of this strategy. The New York nurses received support from memhers of the State Board of Regents, Susan B. Anthony, and the New York Medical Society. In fact, the Medical Society permitted the nurses to use the services of its chief legal counsel. Shannon, *supra* note 13, at 1329.

17. The early constitution of Nursing Boards of Examiners with non-nurses (usually physicians) is yet another factor that impeded the development of nursing as a discipline distinct from medicine. *See* note 11 *supra.*

18. Shannon, *supra* note 13, at 1328.

19. Bullough, *supra* note 15, at 250.

20. *Id.*

21. Mandatory licensure envisions a scheme in which everyone practicing nursing for compensation must be licensed by the state. *See* D'Amico, *Nursing Practice Acts Revisions,* 22 ASS'N OPERATING ROOM NURSES J. 105 (1975).

> The practice of professional nursing means the performance for compensation of any act in the observation, care and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness in others, or in the supervision and teaching of other personnel, or the administration of medications and treatments prescribed by a licensed physician or dentist, requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical, and social sciences. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures.[23]

The last sentence of the definition appears unnecessarily restrictive and may have been the result of a political desire not to antagonize the medical profession.[24] Further, the definition presented real problems for nurses acting beyond the scope of their authority.[25] These problems arose when state legislatures incorporated this definition in their nursing practice acts. Nurses at that point often acted in an independent manner that exceeded the permissible scope of practice. Finally, the definition does not appear to describe accurately nursing practice as it existed in 1955.[26] Concern with the restrictive nature of this definition, along with the trend toward increased education of nurses, led the American Nurses Association in 1970 to amend its definition of nursing practice to authorize certain acts of diagnosis or prescription.[27] This amendment was intended to legitimize the nurse's expanded role in providing health care.

Following this amendment, the third period of nursing licensure laws began. Approximately thirty states have amended their nursing licensure laws since 1970,[28] adopting several different approaches. One approach, typified by Idaho's law,[29] calls for the medical and nursing community jointly to develop areas for expanded

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22. Bullough, *supra* note 15, at 250.

23. *ANA Board Approves a Definition of Nursing Practice,* 55 AM. J. NURSING 1474 (1955).

24. Interview with Rosamond Gabrielson, Immediate Past President of the American Nurses Association, in Nashville, Tennessee (Feb. 14, 1977).

25. For a case study of the problems created by a restrictive definition of nursing practice in Colorado, see Note, *Acts of Diagnosis by Nurses and the Colorado Professional Nursing Practice Act,* 45 DEN. L.J. 467 (1968).

26. Bullough, *supra* note 15, at 251.

27. The amendment provided:

> A professional nurse may also perform such additional acts, under emergency or other special conditions, which may include special training, as are recognized by the medical and nursing professions as proper to be performed by a professional nurse under such conditions, even though such acts might otherwise be considered diagnosis and prescription.

D'Amico, *supra* note 21, at 106.

28. Bullough, *supra* note 15, at 252.

29. IDAHO CODE ANN. § 54-1413 (Bobbs-Merrill Supp. 1976).

nursing responsibility. Other states, exemplified by Maine,[30] permit all nurses to act independently of a physician's orders when a physician delegates the authority to act in a specific area. Finally, some states, led by New York, frankly acknowledge that nurses may practice in a manner reflecting that nursing is a profession independent from medicine. The New York definition states:

> The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential health problems through such services as casefinding, health teaching, health counseling and provision of care supportive to or restorative of life and well being, and executing medical regimens prescribed by a licensed or otherwise legally authorized physician or dentist. A nursing regimen shall be consistent with and shall not vary any existing medical regimen.[31]

Provisions such as the New York statute recognize that nurses have a knowledge base that is distinct from that of the medical profession, and that nurses should be allowed to act independently on the basis of their special knowledge.

Further changes should be anticipated. The New York Nurses Association presently is lobbying in the state legislature for passage of its 1985 proposal, which, if enacted, would require all nurses seeking licensure after 1985 to hold a baccalaureate degree.[32] Since an individual currently may enter the nursing profession by earning an associate degree,[33] a diploma,[34] or a baccalaureate degree,[35] the proposal has been the subject of intense debate,[36] and success is uncertain at this point.[37]

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30. ME. REV. STAT. ANN. tit. 32, § 2102 (West Supp. 1977).

31. N.Y. EDUC. LAW § 6902 (McKinney Supp. 1977).

32. For a description of this proposal and arguments for and against its adoption, see McGriff & Sims, *Two New York Nurses Debate the NYSNA 1985 Proposal*, 76 AM. J. NURSING 930 (1976). This proposal has encountered legislative opposition in the Assembly Committee on Higher Education. 77 AM. J. NURSING 1093 (1977).

33. To receive an associate degree, an individual must complete two years of formal education and training, usually at a community college.

34. To receive a diploma, an individual must complete three years of training at a hospital. In many diploma programs students receive some formal educational training through affiliation with a neighboring college or university.

35. Baccalaureate programs are found at four-year colleges and universities, and graduates of these programs receive a bachelor's degree in nursing. In addition there are programs that offer a Master's Degree and a Doctoral Degree in Nursing. In these advanced programs students can concentrate in a clinical area of nursing (*e.g.*, surgery or psychiatry) or in administrative or educational areas.

36. McGriff & Sims, *supra* note 32, at 932-34; *Editorial*, 1976 J. OBS. GYN. NEONATAL NURSING 6.

37. Interview with Dr. Ingeborg Mauksch, Professor of Nursing and Director of the Robert Wood Johnson Foundation Project, Vanderbilt University, in Nashville, Tennessee (Jan. 22, 1977).

D. The Development of Nursing Standards of Practice

The relationship of the various nursing organizations to each other and to nursing generally has had an important effect on the movements to define standards of practice and to develop a certification program.[38] There are two major national nursing organizations, the American Nurses Association and the National League for Nurses. Although they attempt to work cooperatively, they have different foci. The American Nurses Association (ANA), the professional organization of registered nurses, sets standards for nursing education and practice and represents nurses on legislative matters concerning health, education, and general welfare. The National League for Nurses (NLN), on the other hand, stresses improvement of nursing services and educational programs through accreditation, consultation, testing, research, and publication.[39] Besides these two major groups, there are a number of specialty organizations for individuals with special interest in a particular area of practice.[40] Although the American Nurses Association is the only national organization with the capability to institute and develop programs that are applicable to nurses generally, other organizations facilitate acceptance of these programs by all nurses.

The development of standards has been directed at setting minimum levels of acceptable performance and has attempted to provide the consumer[41] with a means of measuring the quality of nursing care he receives.[42] The certification movement, on the other hand, has had as its goal the recognition of excellence of performance.[43]

Turning first to the movement for the development and implementation of standards, the ANA defines a standard as an

38. Both movements developed during the same period of time—the last two decades—and both movements reflect a common theme—the improvement of nursing practice. These movements further underscore the emerging sense of professionalism in nursing.

39. FLANAGAN, *supra* note 6, at 651-53.

40. Two examples of these specialty organizations are the Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG) and the Association of Operating Room Nurses (AORN).

41. Throughout this note the terms "client" and "consumer" are used interchangeably with the more traditional term "patient." This reflects the change in nursing that stresses individual involvement in care and decisions concerning that care. "Patient" suggests a more passive role in receipt of care.

42. FLANAGAN, *supra* note 6, at 219. In its preface to the first published standard, the American Nurses Association stressed: "A profession must seek control of its practice in order to guarantee the quality of its service to the public." AMERICAN NURSES ASS'N, STANDARDS OF NURSING PRACTICE (1973).

43. Schrader, *ANA Changes Certification Program,* 24 ASS'N OPERATING ROOM NURSES J. 203 (1976).

"authoritative statement by which the quality of practice, service, or education can be judged."[44] The ANA made rapid progress in implementing its standards following an organizational revision of the ANA in 1966 that created five divisions of practice that corresponded to distinct specialty areas.[45] Each new ANA division was charged with the development of standards in its own specialty area following a general format developed by the joint effort of the chairpersons of each division. The development of the standards came to a halt in 1970 due to the ANA's financial problems and disagreement as to the form the standards should take.[46] Once the temporary financial problems were resolved, however, work began anew on the standards. Generic standards, applicable to all nurses in all areas of practice, were completed by the end of 1971, and by the end of 1975 standards in the various specialty areas also had been published.[47]

At the same time that the American Nurses Association was developing standards, various specialty groups outside ANA also were involved in the process of standard making. This involvement took two basic forms. While some specialty groups worked with the ANA in the joint formulation of standards,[48] other groups developed and published their own standards.[49] These separate standards can, however, be viewed as complementary to the parallel ANA standards.[50]

The ANA standards include general standards and assessment factors that can be used to determine whether the standard has been met.[51] For instance, one standard for medical-surgical nursing is:

> The collection of data about the health status of the patient is systematic and continuous. These data are communicated to appropriate persons, recorded and stored in a retrievable and accessible system.[52]

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44. FLANAGAN, *supra* note 6, at 219a.

45. AMERICAN NURSES ASS'N, PROCEEDINGS OF THE ANA 1966 CONVENTION 45 (1966). For a summary of the debate that preceded the adoption of these changes, see *id.* at 37-45. The five specialty areas that were created are: (1) Community Health, (2) Geriatrics, (3) Maternal and Child Health, (4) Medicial-Surgical, and (5) Psychiatric-Mental Health.

46. Interview with Ms. Gabrielson, *supra* note 24.

47. FLANAGAN, *supra* note 6, at 223-25.

48. This approach was adopted by a number of organizations in the medical-surgical specialty area. Thus emergency room, coronary care, and other groups participated in the formulation of the medical-surgical standards. *Id.* at 226.

49. *See, e.g.*, NURSES ASS'N OF THE AM. COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, OBSTETRIC, GYNECOLOOICAL AND NEONATAL NURSING FUNCTIONS AND STANDARDS (1974) [hereinafter cited as NAACOG].

50. Interview with Dr. Mauksch, *supra* note 37.

51. *See, e.g.*, AM. NURSES ASS'N, STANDARDS OF MEDICAL-SURGICAL NURSING PRACTICE (1974).

52. *Id.* at 2.

The assessment factors used in measuring compliance with this standard include the evaluation of fluid and electrolyte balance, metabolic regulation, cardiovascular and respiratory output, and the complete collection of relevant data.[53] The standards for each specialty group developed by ANA follow the same pattern. While the standards are similar to the one described above, and are thus general, when combined with the assessment factors that follow each standard, they provide a useful framework for analyzing whether the nursing action in question complied with what the profession believes to be the appropriate standard of care.

The most complete standards developed by an organization outside the ANA are those published by the Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG).[54] These standards detail nursing functions during labor, delivery, and after childbirth. In addition they specify behaviors appropriate for all nurses specializing in this area of practice, behaviors appropriate for specially prepared nurses, and behaviors inappropriate for nurses. For instance, the standards allow a nurse, during postpartum, to administer oral, intramuscular or intervenous medication and to initiate blood transfusion and intravenous solutions that have been ordered by the physician. In addition the specifically trained nurse may remove sutures and remove vaginal packing. According to these standards it is inappropriate, however, for any nurse to remove uterine packing and suprapubic catheters.[55] The same framework is followed in describing nursing functions in antepartum, labor and delivery, and neonatal care. Standards that are this specific make it relatively easy to determine if the nurse acted within the scope of permissible activity.

E. A National Certification Program

Coinciding with the development of standards to measure nursing care, a program to define, establish, and implement a program of certification for nurses also developed. Certification recognizes the attainment of specialized knowledge and skills beyond those required for safe practice. The American Nurses Association initially desigued its certification program to recognize excellence in the clinical practice of nursing.[56] Initially, the then eight occupational sections of the American Nurses Association attempted to

53. *Id.*
54. *See* note 49 *supra* and accompanying text.
55. NAACOG, *supra* note 49, at 10-11.
56. FLANAGAN, *supra* note 6, at 231.

develop standards for certification. After a few years of experimentation, however, the ANA determined that specialty clinical groups were better suited for the job of developing certification guidelines.[57] After amending the American Nurses Association bylaws in 1966 to establish the current five specialty areas,[58] the American Nurses Association delegated the task of implementing a certification program to interim certification boards that corresponded to the five clinical areas of practice. Initial proposals for multiple certification programs in each clinical area were considered and rejected.[59] Finally, the ANA determined that there would be one certification for each clinical area of practice.[60] To qualify for certification an applicant may be a graduate from any basic nursing program,[61] must practice for a set period of time in the clinical area in which certification is sought, and must demonstrate excellence of knowledge and performance through written examinations and written documentation of nursing practice.[62] The first certification examinations were held in 1975, and by the end of that year 304 nurses had been awarded certification.[63]

Controversy has surrounded the certification program, and its future is uncertain. Although some specialty groups outside the American Nurses Association have worked with and assisted in the initiation of the certification program,[64] others have not. The first significant indication of opposition to the American Nurses Association certification program surfaced in 1974 when the American Academy of Pediatrics announced that it did not support the ANA certification program in pediatrics.[65] This dispute centered around the degree of independence nurses should be allowed in their practice and the amount of input physicians should have in designing the certification measurement tools. As a result of the controversy,

57. *Id.* at 229-31.

58. *See* note 45 *supra* and accompanying text.

59. For a discussion of these proposals, see FLANAGAN, *supra* note 6, at 232-34.

60. *Id.*

61. *Id.* at 234.

62. *Id.* at 234-35.

63. Am. Nurse, Feb. 15, 1976, at 18, col. 3.

64. *ANA and NAACOG Announce Joint Certification in Maternal, Gynecologic, and Neonatal Nursing*, 4 J. OBS. GYN. NEONATAL NURSING 58 (1975).

65. Letter from Dr. Robert Frazier to Fellows of the American Academy of Pediatrics (Jan. 16, 1974). This letter provoked a letter in response from the American Nurses Association. This response letter provides further details of the controversy between the American Nurses Association and the American Academy of Pediatrics. Letter from Dr. Eileen Jacobi to *Pediatric Nurse Practitioner* and Fellows of the American Academy of Pediatrics (Jan. 29, 1974).

the American Academy of Pediatrics apparently intends to develop its own certification program.[66]

In 1976 the American Nurses Association considered altering its certification program in order to offer a two-track certification program. This change would offer a separate certification for nurses with advanced degrees.[67] This proposed change produced considerable controversy at the 1976 ANA convention.[68] In addition, the proposed change prompted the Association of Operating Room Nurses to withdraw their support, at least temporarily, from the American Nurses Association certification program.[69] As a result of these uncertainties the certification program in the medical-surgical area apparently will not be offered in 1977.[70] Therefore, it is difficult to predict whether certification will become an important component of nursing practice.

F. Differentiation of Nurses by Basic Academic Program

As described above,[71] there are currently three ways of gaining entry into the profession of nursing. Traditionally hospital diploma programs were the major source of new nurses,[72] but associate degree and baccalaureate programs are becoming increasingly popular and might supplant the hospital diploma programs as the primary means of entry into the profession. In 1960, 78.2 percent of all new nursing students enrolled in diploma programs compared to 4.2 percent in associate degree programs and 17.6 percent in baccalaureate degree programs.[73] There had been a dramatic shift by 1972 when 31.7 percent of all new students entered diploma programs while 39.3 percent entered associate degree programs and 29.1 percent entered baccalaureate programs.[74] If this trend continues, as it

66. Letter from Dr. Robert Frazier, *supra* note 65.

67. Schrader, *supra* note 43, at 203.

68. The proposal was debated for over two and a half bours at the Convention and was sent back for further consideration. Interview with Ms. Gabrielson, *supra* note 24.

69. Dodge, *Certification an option for OR Nurses?*, 25 ASS'N OPERATING ROOM NURSES J. 407 (1977).

70. *Id.* at 410.

71. *See* notes 33-35 *supra.*

72. In part the first licensure movement, *see* notes 15-20 *supra* and accompanying text, was an attempt to standardize the hospital nursing education program that began to appear at the end of the nineteenth century.

73. AM. NURSES ASS'N, FACTS ABOUT NURSING 1972-73, Table II-A-1, at 73 (1973).

74. *Id.* Further documenting the movement away from diploma programs are the number of graduates of the various programs. In 1961 82.5% of all new nurses graduated from diploma programs, 13.8% from baccalaureate programs, and 3.7% from associate degree programs. By 1972 the percentages had changed, and 41.7% of all new graduates were from diploma programs, 37% were from associate degree programs, and 21.3% were from baccalau-

seems certain to do, there likely will be only two ways of entry into nursing—by earning either an associate or a baccalaureate degree. Currently the profession includes many who favor requiring entry from a baccalaureate program,[75] but because the number of graduates from an associate degree program currently practicing is quite high, it is unlikely that such a change will occur in the near future.

Because there are multiple ways of becoming a nurse, the profession is beginning to differentiate nurses in terms of expected levels of performance based on the manner in which an individual entered nursing. Such differentiation is sound since graduates of two year and four year programs should have different skills.[76] Until recently, however, there were "several levels of nursing education but only one level of practice."[77] Traditionally only one distinction among nursing skills has been made, couched in terms of technical skills (associate degree) contrasted with analytical and intellectual skills (baccalaureate degree).[78] Dr. Helen Yura[79] suggests the establishment of different expectations for different level nurses.[80] According to Dr. Yura all nurses have the basic level technical competencies necessary to perform routine nursing tasks. In addition to

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reate programs. *Id.*, chart 4, at 77. The number of hospitals offering diploma programs declined from 874 in 1962 to 543 in 1972. During the same time period the number of associate degree programs increased from 84 to 541, and the number of baccalaureate programs increased from 178 to 293. *Id.*, Table II-B-2, at 97.

75. *See* note 32 *supra* and accompanying text.

76. The discussion on role and performance expectation assumes a two-tier system: baccalaureate and non-baccalaureate. While this author believes that a dichotomy between solely baccalaureate and associate degree programs is inevitable, *see* note 74 *supra*, the discussion is broad enough to include diploma graduates in the non-baccalaurate category.

The two programs are structured differently. The four-year program is more heavily grounded in the sciences. Thus a typical four-year program will include a full year's study of organic and inorganic chemistry, a course in bacteriology, a year's study of anatomy and physiology, and a course in mathematics. *See, e.g.*, VAND. UNIV. SCH. NURSING CATALOGUE 46 (1976). A typical two-year program will have no chemistry or mathematics requirements. *See, e.g.*, BELMONT COLLEGE CATALOGUE 150-51 (1976). In addition the four-year program emphasizes the psychological and social implication of nursing care to a much greater extent than do two-year programs. These educational differences demonstrate that graduates of four-year programs have a more complete and intensive science background from which to observe, interpret and diagnose patient needs. Further, it seems that the longer exposure to formal education in the four-year program fosters the development of a professional consciousness to a greater extent than can ordinarily occur in a two-year program.

77. SOUTHERN REGIONAL EDUCATIONAL BOARD, A PROPOSED SYSTEM FOR NURSING 49 (1976) (quoting Shehan, *The Name of the Game, Nurse Professional and Nurse Technician*, 1972 NURSING OUTLOOK 442).

78. *See* note 32 *supra* and accompanying text.

79. Assistant Director of the Baccalaureate and Higher Degree Programs, National League of Nursing.

80. Yura, *A Climate to Foster Utilization of the Nursing Process*, in PROVIDING A CLIMATE FOR UTILIZATION OF NURSING PERSONNEL 11 (1975).

these basic skills the baccalaureate degree nurse has the capacity to assess data, select the appropriate nursing intervention, carry out the selected intervention, and evaluate the strategy selected.[81] Associate degree nurses, on the other hand, have the capacity to collect data, select interventions that are standardized, and carry out these interventions (or the intervention planned by others) with a high degree of technical competence.[82] Thus the major difference, according to Yura, is the baccalaureate nurse's increased ability to analyze the collected data and independently select and implement the appropriate nursing intervention.

These ideas have been expanded in a recent study on utilization of nursing personnel published by the Southern Regional Education Board.[83] This study also concluded that associate degree graduates are prepared to perform technical nursing tasks. The study found that nursing care is provided in three different settings—primary,[84] secondary,[85] and tertiary.[86] The study found that associate degree nurses are well prepared to implement plans that are standardized and in common use and to work under the supervision of others.[87] The baccalaureate graduate, on the other hand, is prepared to function in a more independent manner. If this nurse functions in either a secondary or tertiary setting,

> [t]he nursing process no longer will be standardized; procedures to be followed and outcomes to be expected will not be as predictable. More monitoring of the client and his disease process will be required, as decisions on the basis of that monitoring will be made more independently by the nurse.[88]

Baccalaureate nurses in primary care settings are also prepared to

81. *Id.* at 21-22.

82. *Id.* at 23.

83. SOUTHERN REGIONAL EDUCATIONAL BOARD, NURSING CURRICULUM PROJECT: SUMMARY AND RECOMMENDATIONS (1976) [hereinafter cited as SREB].

84. Primary care includes the evaluation of new symptoms, referral of clients to other health care practitioners, and the long-term management of chronic illness. This care usually is provided outside the hospital setting in homes, clinics, and offices. *Id.* at 9; Interview with Ms. Karen Schumacher, Assistant Professor of Nursing, Vanderbilt University, in Nashville, Tennessee (Mar. 13, 1977).

85. Secondary care consists of the care of clients who are experiencing illnesses that are common and well-defined, or who are in need of routine health-illness monitoring. SREB, *supra* note 83, at 8. This type of care usually, but not necessarily, is provided in an inpatient facility *(e.g.,* hospital, nursing home). Interview with Ms. Mary Eccard, Assistant Professor of Nursing, Vanderbilt University, in Nashville, Tennessee (Mar. 17, 1977).

86. Tertiary care is provided to clients whose illnesses are rare or complex and who require specialized nursing care. Tertiary care usually is associated with large medical centers and may include experimentation. SREB, *supra* note 83, at 9.

87. *Id.* at 10-11.

88. *Id.* at 11.

function independently.[89]

The American Nurses Association's Standards for Nursing Education also supports the dichotomy in expected levels of performance, stating that baccalaureate programs are designed to prepare nurses who can use the scientific method and apply it to nursing care problems and who can collaborate with other health care professionals.[90] ANA standards state that associate degree programs, on the other hand, are designed to train nurses to enter practice in positions focusing on direct patient care—nurses who know the limits of their knowledge base and know when to seek assistance.[91]

In summary, the different ways of becoming a nurse do not produce, and are not intended to produce, nurses with identical skills. All nurses have a basic level of proficiency to perform certain required nursing treatments, but nurses with baccalaureate and higher degrees[92] have the added ability to function at an independent level that includes selecting appropriate nursing actions based on analysis of relevant data on the patient.

G. Professional Discipline and Continuing Education

One measure of the professionalization of an occupation is the extent to which the occupational group enforces expected norms of behavior. In the area of professional discipline, to enforce standards, and in the area of continuing education, to maintain and increase competence, nursing is reflecting a growing sense of professionalism.

The recent case of *Scott v. State ex rel. Board of Nursing*,[93] reflects that the nursing profession, through its state boards of nursing, is beginning to examine the conduct of its members and to measure the conduct against certain norms. In *Scott* a nurse was licensed in another state and applied for licensure in Nebraska. The applicant met the objective statutory standards for licensure.[94] The state board of nursing, nevertheless, refused to grant the license

89. *Id.* at 12.

90. AM. NURSES ASS'N, STANDARDS FOR NURSING EDUCATION 17 (1975).

91. *Id.* at 23.

92. Graduate education in nursing also is expanding. In 1972 there were 6,342 nurses pursuing Master's Degrees and 402 pursuing Doctoral Degrees. AM. NURSES ASS'N, FACTS ABOUT NURSING 1972-73, Table II-C-1, at 109 (1973).

93. 196 Neb. 681, 244 N.W.2d 683 (1976).

94. For licensure the relevant Nebraska statute required that the applicant:

(1) be of good moral character;

(2) have completed high school; and

(3) have graduated from a professional school of nursing approved by the state.

The applicant met these qualifications. 196 Neb. at 683, 244 N.W.2d at 686.

because they found that the applicant was guilty of unprofessional conduct.[95] In reaching this conclusion the board received evidence that the nurse-applicant had provided inadequate care to a patient,[96] had left her patients unattended, did not follow procedures for admitting patients, and failed to cooperate with patients or fellow nurses. The board also heard testimony from several nurses that this kind of behavior constituted unprofessional conduct. The board refused to issue the license[97] and the disappointed applicant sought judicial redress. The Supreme Court of Nebraska, rejecting the contention that the board's finding was subject to de novo review by the courts, affirmed the board's decision. The court noted that the board of nursing was composed of professional nurses and concluded that the legislature, in granting licensure authority to the board of nursing, intended the board to use this expertise in making licensure decisions.

Scott is significant for two reasons. First, it demonstrates that state boards of nursing, through their licensure power, have the authority to enforce professional norms.[98] While it is impossible to generalize on the basis of one case, *Scott* at least reflects the kinds of behavior that can be examined in determining whether an individual is guilty of unprofessional conduct. In this case the behavior questioned involved patient care and thus was an evaluation of the nurse's professional behavior. Although *Scott* was set in the context of an application for licensure by a nurse licensed in another state, most boards have been given authority not only to deny such license requests but also to revoke currently issued licenses.[99] The second siguificant aspect of *Scott* is the response of the court. By refusing to allow de novo review by the trial court, the Nebraska Supreme Court has granted a great deal of power to the state board of nursing. This deferral by the courts is appropriate, especially when state boards of nursing are composed of nurses who bring their own expertise to bear in determining questions of professional performance.

95. The state board of nursing was empowered to deny licenses if an applicant was guilty of unprofessional conduct. NEB. REV. STAT. § 71-1, 132.29 (1971).

96. Specifically the board found that the applicant did not recheck the temperature of a seven month old infant who was admitted to the hospital with a reported temperature of 105° and further failed to notify the physician of the infant's condition. 196 Neb. at 684, 244 N.W.2d at 686.

97. *Id.*

98. Most states have granted their state boards of nursing power to deny or revoke licenses in a fashion similar to the Nebraska statute and decisions. *See, e.g.*, COLO. REV. STAT. § 12-38-217 (1973); MICH. COMP. LAWS § 338.1171(c) (1976); WYO. STAT. § 33-288 (1957).

99. *Id.*

In the last five years, continuing education has become an important force in the practice of nursing. At the present time continuing education in nursing exists as a voluntary program in the majority of states.[100] Continuing education is, however, increasingly being used as a mandatory requirement for relicensure with four states already adopting the mandatory system.[101] Continuing education for nursing is viewed as a means of ensuring that all nurses are exposed to new developments in the field. In addition, the technological nature of health care and the critical importance of understanding new discoveries in providing safe and effective health care argue in favor of a continuing education program.[102]

The voluntary continuing education program is in effect in virtually all states. While the specifics of each program vary from state to state there are basic similarities. Most of these programs are based on contact hours.[103] Typically ten contact hours will equal one continuing education credit, and to meet the program's requirements it is necessary to gain a specified number of credits. Most states have adopted their programs to comply with ANA criteria in order to become part of the ANA national information storage system. This system facilitates transfers of credits from one state to another if the nurse relocates.

The mandatory program of continuing education has been adopted in California (effective 1978),[104] Florida (effective March 1, 1980),[105] Kansas (effective July 1, 1978),[106] and Minnesota (effective January 1, 1978).[107] In addition, Oregon[108] has a mandatory continuing education program for nurses who have not practiced in the five most recent years, and Colorado, Louisiana, and South Dakota[109] have permissive provisions allowing the state board of nursing to

100. *The Status of Continuing Education—Voluntary or Mandatory,* 1977 AM. J. NURSING 410 [hereinafter cited as *Continuing Education*].

101. California, Florida, Kansas, and Minnesota.

102. Hislop & Vallar, *Continuing Education Revisited,* 1976 SUPERVISOR NURSE 36.

103. A contact hour is either 50 minutes of an organized learning experience or two hours of planned and supervised clinical practice.

104. CAL. BUS. & PROF. CODE § 2811.5 (West Supp. 1977).

105. FLA. STAT. ANN. § 464.051(3)(k) (West Supp. 1977).

106. KAN. STAT. ANN. § 65-1117 (Supp. 1976).

107. MINN. STAT. ANN. § 148.231 (West Supp. 1977).

108. ORE. REV. STAT. § 678.050(2)(b) (Supp. 1977).

109. *See Continuing Education, supra* note 8, at 412. Also, in May New Mexico adopted a mandatory continuing education program and Iowa appears close to adopting a similar plan. 77 AM. J. NURSING 1100 (1977). In Rhode Island the legislature tabled the proposal, and in Texas the American Medical Society opposed the bill. As a result, it never emerged from committee. 77 AM. J. NURSING 1119 (1977).

establish continuing education programs. Further, in five states[110] nurses, through their state nurses associations, are supporting the introduction of mandatory continuing education programs. While the specifics of each program vary from state to state, all states with mandatory continuing education programs condition renewal of the license to practice on the successful completion of a specified number of continuing education programs.[111] Continuing education, in either its voluntary or mandatory form, is another reflection of the increasing professionalization of nursing.

II. The Courts and the Nurse

A. *The Appropriate Statute of Limitation*

In determining the appropriate statute of limitation in claims against nurses, courts necessarily must confront the question whether nurses should be treated as professionals. If nurses are professionals, actions against them should be based on malpractice theory rather than usual negligence standards. The standard to be used in turn will affect the selection of an appropriate statute of limitation; the need for, and quality of, expert testimony required to establish culpability; and the selection of a proper standard of care.

The recent spate of malpractice litigation has led to statutory change in many states to provide greater protection against malpractice claims. Many states, in adopting these changes, have established a much broader definition of potential defendants protected by the malpractice statute.[112] Other states have specifically limited their statutes to "professional groups," which does not include nurses.[113] A third category of states does not define the group of individuals subject to the malpractice statutes.[114] Many of these statutes currently are being challenged and some have not withstood constitutional scrutiny.[115] Thus, in those states whose new

110. These states are Massachusetts, Michigan, New York, Rhode Island, and Texas.

111. In California, for instance, it will be necessary to complete as much as 30 hours of continuing education in the year preceding the renewal application in order to have a license renewed. *See* Cal. Bus. & Prof. Code § 2811.5 (West Supp. 1977).

112. *See, e.g.*, Alaska Stat. § 09.55.560 (Michie Supp. 1977); Ariz. Rev. Stat. § 12-561 (West Supp. 1977); Cal. Civ. Proc. Code § 340.5 (West Supp. 1977); Iowa Code Ann. § 614.1(9) (West Supp. 1976).

113. *See, e.g.*, Ala. Code tit. 7, § 25(1) (Michie Supp. 1973); Conn. Gen. Stat. Ann. § 52-584 (West Supp. 1977).

114. *See, e.g.*, Me. Rev. Stat. tit. 14, § 753 (1964); Neb. Rev. Stat. § 25-208 (1975); N.H. Rev. Stat. Ann. ch. 508:13 (Supp. 1973).

115. *See, e.g.*, Wright v. Central Du Page Hosp. Ass'n, 63 Ill.2d 313, 347 N.E.2d 736 (1976). The Illinois statute was found fatally defective on three grounds. First, the $500,000

malpractice statutes have been rejected by the courts and in those states that have not defined the group subject to the malpractice statute, the courts will have to determine whether nurses are subject to the malpractice statute of limitation,[116] which is shorter than the negligence statute of limitation. Further, the discussion below indicates that those state legislatures that have failed to make their malpractice statutes applicable to nurses should reconsider that exclusion.

In *Richardson v. Doe,*[117] the leading case dealing with statutes of limitation,[118] the court determined that a nurse was not subject to the shorter malpractice statute of limitation. The decision rested on two lines of analysis. The court based the first line of analysis on its view of nursing practice and the second on two earlier New York cases. Neither line of analysis supports the conclusion reached by the *Richardson* court, and the result seems clearly wrong and should not be followed today.

The court first determined that nurses did not need the protection of the malpractice statute of limitation because a nurse

> is to observe and record the symptoms and reactions of patients. A nurse is not permitted to exercise judgment in diagnosing or treating any symptoms which the patient develops. . . . A nurse by the very nature of her occupation is prohibited from exercising an independent judgment in these areas.[119]

These conclusions, although based on a limited and incorrect

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limitation on the maximum recovery for medical malpractice actions was found to be arbitrary and special interest legislation in violation of the Illinois constitution. Secondly, the three-member medical malpractice review panel (consisting of a judge, an attorney, and a physician) had been empowered to make findings of fact and conclusions of law and the court found this was a restriction of the right to a jury trial guaranteed by the Illinois constitution. Finally, a statutory requirement of prior hearing and approval before an increase on medical malpractice insurance policy premiums was also found to be special interest legislation.

In Oregon Medical Ass'n v. Rawls, No. 421-496 (Ct. App. Ore. May 4, 1976), a portion of the new Oregon malpractice statute was found unconstitutional. The statute attempted to deprive physicians and hospitals of the common law right to indemnity. The court found that this violated an Oregon constitutional provision that required the legislature to provide a substitute remedy when it abolished a common law remedy. This provision was then severed from the rest of the statute.

116. For a well documented, if somewhat dated, study of the interpretation of malpractice statute of limitations problems, see Lillich, *The Malpractice Statute of Limitations in New York and Other Jurisdictions,* 47 CORNELL L.Q. 339 (1962).

117. 176 Ohio St. 370, 199 N.E.2d 878 (1964); Annot., 8 A.L.R.3d 1331 (1965).

118. The *Richardson* holding was followed in Kambas v. St. Joseph's Mercy Hosp., 389 Mich. 249, 205 N.W.2d 431 (1973), and Cordial v. Grimm, 346 N.E.2d 266 (Ind. 1976). Both of these decisions appear to have been rendered moot by recent legislative enactments. *See* IND. CODE ANN. § 16-9.5-1-1 (Burns Supp. 1976); MICH. COMP. LAWS § 600.5838 (West Supp. 1977).

119. 176 Ohio St. at 372, 199 N.E.2d at 880.

view of nursing practice, are understandable. As noted earlier,[120] the nursing profession itself, in its first definition of nursing practice, claimed that nurses did not perform acts of diagnosis. While that definition was, in the view of current commentators, unnecessarily restrictive and inaccurate,[121] it does give some credence to the Ohio court's conclusions. Whatever historical validity the decision might have had, however, has been eroded by the current licensure movement, which specifically recognizes that nurses function independently and indeed perform acts of diagnosis.[122] Thus conclusions based on historical ideas of nursing practice should be modified to reflect current reality.

The second basis of the *Richardson* decision, New York precedent, is also suspect. In *Isenstein v. Malcomson*[123] the court refused to apply the malpractice statute of limitation to a nurse who left a hot water bottle on the exposed flesh of an unconscious patient. The *Isenstein* court implied that malpractice actions were limited to physicians and attorneys. Although the rationale of the court in *Isenstein* also is understandable and the result appears correct, the case was decided prior to the second phase of nursing licensure laws[124] at a time when many nurses did not have even a high school education.[125] Again, results that are correct in a given historical period should be studied in context before being applied to a different context. The second New York opinion, *Wolff v. Jamaica Hospital*,[126] is not helpful. It is a one page opinion that concludes, without analysis, that malpractice actions are limited to physicians and surgeons.

The *Richardson* court failed to mention *Davis v. Eubanks*,[127] a decision four years earlier by a lower level Ohio court that concluded that nurses were subject to the malpractice statute of limitation. In *Davis* the court found that since the legislature defined nurses as professionals, the courts should accept this legislative determination.[128] This approach, focusing on the current level of nursing prac-

120. *See* note 23 *supra* and accompanying text.
121. *See* note 24 *supra* and accompanying text.
122. *See* notes 28-31 *supra* and accompanying text.
123. 227 App. Div. 66, 236 N.Y.S. 641 (1929).
124. *See* note 21 *supra* and accompanying text.
125. *Id.*
126. 11 App. Div. 2d 801, 205 N.Y.S.2d 152 (1960).
127. 83 Ohio L. Abs. 28 (C.P. Franklin County 1960).
128. In *Davis*, in order to determine if nurses were professionals, the court reviewed the nursing licensure statute. The court noted that the statute repeatedly referred to nurses as professionals and reasoned that this indicated that the legislature intended nurses to be treated as professionals. *Id.* at 31.

tice and the legislative recognition of that practice, appears sound. Once it is recognized that nursing is founded on an independent, specialized core of knowledge and theory and that nurses use this body of knowledge to prescribe and to diagnose, it is only logical to treat them as professionals and apply a malpractice statute of limitation to nurses.

The analysis described above can be demonstrated by interpreting the statutes of two states, New York and Nebraska. New York has often been the leader in establishing rights for nurses; indeed, New York's definition of nursing is broader than that of most states and provides the greatest area for independent nursing action.[129] This very progressiveness, however, could produce the anomalous result that nurses are not covered by the recently enacted New York malpractice statute of limitation, which recognizes an independent basis of nursing action. The relevant statutes[130] also distingnish between medical diagnosis and nursing diagnosis and between treatments necessary to implement a nursing regimen and treatments necessary to implement a medical regimen. The statute thus has created a clear demarcation between nursing and medical acts. These distinctions, by themselves, indicate a legislative recognition of the right and ability of nurses to function in an independent manner. Problems develop, however, when reference is made to the malpractice statutes of limitation. Recent amendments to New York law have set the statute of limitation for medical malpractice actions at two years and six months. Since the legislature has made a clear distinction between medical actions and nursing actions in the section defining the scope of nursing practice, it is plausible to argne that the term "medical malpractice" in the statute of limitation section should also reflect this distinction and therefore apply only to claims against physicians and surgeons. Such a result, while argnably correct from a statutory construction point of view, is wrong from a policy viewpoint. Malpractice statutes of limitation are designed to protect professionals who are exposed to liability due to the exercise of independent judgment.[131] Because the New York nursing practice deflnition statute recognizes that nurses are professionals and exercise independent judgment, to ex-

129. *See* note 23 *supra* and accompanying text.

130. N.Y. EDUC. LAW §§ 6901, 6902 (McKinney Supp. 1977).

131. In *Richardson v. Doe* the Ohio Supreme Court noted that "It is in the areas of diagnosis and prescription that there is the greatest danger of unwarranted claims." 176 Ohio St. at 372, 199 N.E. 2d at 880. It was this exposure to liability resulting from the exercise of professional independent judgment that justified the special consideration and protection of malpractice statute.

clude them from protection of the malpractice statute of limitation contradicts the major reason for such recognition.

Analysis of the relevant Nebraska statutes produces a more satisfactory solution. The Nebraska statutes set a two year statute of limitation for malpractice actions but do not specify which groups are subject to the statute.[132] In determining whether nurses should be subject to this statute one must turn to the section defining nursing practice. That section states:

> The practice of professional nursing shall mean the performance of any professional services requiring the application of principles of biological, physical, or social science and nursing skill in the care of the sick, in the prevention of disease, or in the conservation of health.[133]

It therefore can be argued that by defining nursing in terms of performing professional services, the legislature intends to treat nurses as professionals, and that demonstrable legislative intent to treat nurses as professionals should be followed by applying the shorter malpractice statute of limitation to nurses.

B. The Need for Expert Witnesses in Nursing Malpractice Actions

The traditional rule in malpractice actions requires expert testimony to support a finding of negligence.[134] Although a variety of rationales has been offered to support this requirement,[135] the most convincing rationale apparently is the respect and deference that the courts have for the learning of a fellow profession.[136] One commentator, in expanding on the justification for this rationale in the medical malpractice area, has suggested that since a large measure of judgment enters into the practice of medicine, this judgment should be free to operate in the best interests of the patient.[137] He contends that if every judgment made by the physician were subject to second guessing on the part of lay persons, the physician would be reluctant to exercise that degree of independent judgment necessary to benefit the patient.[138]

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132. NEB. REV. STAT. § 25-208 (1975). Section 25-207 sets a four-year statute of limitations for simple negligence actions.

133. NEB. REV. STAT. § 71-1,132.05 (1971).

134. W. PROSSER, THE LAW OF TORTS 164 (4th ed. 1971) [hereinafter cited as PROSSER].

135. Prosser suggests that this is permitted either because the physician has impliedly represented that he will follow customary medical methods and thus should be judged in accordance with those methods or because of the respect the legal community has for a fellow profession and the reluctance to establish liability based on uneducated judgments. *Id.* at 165.

136. *Id.*

137. McCoid, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549 (1959).

138. This rationale is applicable to this study of nurses and nursing malpractice. As

Any discussion of the need for expert testimony in a malpractice action presents the question whether a profession should be allowed to set its own standard of care.[139] As noted by Prosser,[140] this is a unique concession to professional groups. Keeping in mind that the major reason for requiring expert testimony and for allowing the profession to set its own standards is to encourage the exercise of independent professional judgment, the majority of courts have extended this privilege to the medical profession. Since nursing has recently published its own standards of practice, which can serve as the basis for evaluating nursing actions, the privilege of a profession to set its own standards should be extended to the nursing profession as well.

The recent Washington Supreme Court case of *Helling v. Carey*[141] casts doubts on the privilege of a profession to set its own standards. In *Helling* the plaintiff, a woman in her twenties, consulted an opthalmologist about her nearsightedness. Although the doctor fitted her with contact lenses, her complaints persisted. Finally, it was determined that she suffered from glaucoma, and because of the delay in diagnosis, suffered irreversible eye damage. Expert testimony offered at trial established that it was not accepted practice routinely to administer a glaucoma test to patients under forty. The lower court found for the defendant physician but on appeal, the Washington Supreme Court reversed and held the defendant liable, as a matter of law, for not having administered routinely the glaucoma test. The decision has been criticized as an unwise attempt by a court to make medical judgments that professionals knowledgeable in the field are better suited to make.[142] Returning to the initial reason for requiring expert testimony, it is apparent that a result such as that reached in *Helling* tends to deter the free exercise of a professional's independent judgment. Realizing this to be so, the Washington legislature acted to require a return to pre-*Helling* malpractice standards.[143] Additionally, a subsequent

described above, nurses are receiving the education to act in a more independent manner, *see* note 92 *supra* and accompanying text, and licensing laws are being changed to permit nurses legally to act in this more independent manner.

139. For an excellent discussion of the validity of letting the medical profession set its own standard of care, see King, *supra* note 1.

140. PROSSER, *supra* note 134, at 164.

141. 83 Wash. 2d 514, 519 P.2d 981 (1974), *noted in* 20 N.Y.L.F. 669 (1975); 28 VAND. L. REV. 441 (1975).

142. King, *supra* note 1, at 1250.

143. WASH. REV. CODE § 4.24.290 (West Supp. 1975) requires a plaintiff in a medical malpractice case to "prove by a preponderance of evidence that the defendant or defendants failed to exercise that degree of skill, care and learning possessed by other persons of the same profession. . . ."

Washington appellate level case, *Meeks v. Marx*,[144] indicates a judicial reluctance to extend *Helling*. In *Meeks* the plaintiff brought an action against a physician for failure to discover and disclose that the plaintiff suffered from osteomyelitis (inflammation of the marrow of the bone). This condition had led to the amputation of the diseased leg. As in *Helling*, further testing at an early point likely would have disclosed osteomyelitis, and the leg might not have been amputated. Nevertheless, the court specifically limited *Helling* to its facts and refused to extend it to a similar case. The court noted:

> We have carefully considered plaintiff's contention and the effects our decision would surely have upon other cases yet to be decided were we to attempt a rule of general application from *Helling* and apply it to the facts of this case. A thorough analysis of that decision leads us to conclude that the holding was intended to be restricted solely to its own "unique" facts, *i.e.*, cases in which an opthalmologist is alleged to have failed to test for glaucoma under the same or similar circumstances.[145]

The import of the legislative action and the court's language is clear: extension of *Helling* and refusal to follow the profession's standards in determining malpractice are unlikely in the immediate future.

In considering malpractice actions, two major questions must be confronted. The first is whether the above-described rationale should apply to nurses. The second question is, assuming the first question is answered in the affirmative, who is qualified to serve as an expert witness. The correct solution to both inquiries depends, in large part, on the determination of whether nursing is a profession.

The nature of traditional nursing practice has caused a fair amount of confusion as to whether expert witnesses are necessary in nursing malpractice actions. This confusion results from the realization that traditionally nurses have performed both routine, nontechnical tasks as well as specialized nursing tasks. If, in considering the case law in this area, the dispute is analyzed in terms of what action by the nurse is being complained about, it is possible to make some sense out of the relevant decisions. In addition, it is possible to use these precedents accurately in view of the current changes taking place in nursing.[146]

144. 15 Wash. App. 571, 550 P.2d 1158 (1976).

145. *Id.* at 575, 550 P.2d at 1162.

146. Thus the older cases should be studied and analyzed in terms of both the state of nursing practice and the nature of the nursing act. Findings of liability based on dependent nursing acts, while historically accurate, should not be used to preclude the current necessity of expert nursing testimony to prove liability under an expanded standard of care.

Jones v. Hawkes Hospital[147] is one of the classic cases dealing with the issue of expert witnesses in nursing malpractice litigation. In *Jones* the plaintiff was in the hospital's labor room prior to the birth of her first child. She was sedated and had made previous attempts to climb out of bed. After plaintiff's contraction ended, the nurse primarily responsible for plaintiff's care temporarily left the room in order to check information concerning the plaintiff and to respond to a request for assistance from a physician. During the nurse's five minute absence, plaintiff fell out of bed and was injured.[148] The defendant hospital appealed the trial court's finding of liability, claiming that the plaintiff needed to produce expert testimony to show that the nurse, the hospital's servant, failed to meet the applicable professional standard of conduct. The majority of the Ohio Supreme Court rejected this contention.[149] In justifying this result the court noted that six members of the jury in the instant case were women and took judicial notice of the fact that most women jurors were mothers or grandmothers and that "[t]hey know probably as much if not more about childbirth than many witnesses who might be put on the witness stand."[150] Thus under the majority approach it was unnecessary to resort to expert testimony to determine that the nurse in question was negligent. This argument, as the dissent correctly noted, missed the point.[151] In view of the paramount justification for demanding expert witnesses in malpractice actions—encouraging the exercise of independent judgment[152]—the dissent's approach is sound. In this case the nurse's decision to leave the room in order to perform other nursing tasks and to assist in the care of others might have been erroneous. If so, that judgment should have been evaluated by fellow nurses instead of by a jury of lay people. This malpractice approach will benefit the health care consumer because care will be administered according to sound nursing principles and will encourage the nurse to determine care priorities according to these principles.

Cases subsequent to *Jones* that have attempted to focus on the nature of the nursing action have not required expert testimony when the court concludes that the action at issue is within the

147. 175 Ohio St. 503, 196 N.E.2d 592 (1964).

148. *Id.* at 505, 508, 196 N.E.2d at 594, 598.

149. Both *Hawkes* and *Richardson, see* notes 98-109 *supra* and accompanying text, were decided in the same year by the Ohio Supreme Court. Taken together, hoth opinions indicate that the Ohio court was not sympathetic to the claim that nursing was a profession.

150. 175 Ohio St. at 506, 196 N.E.2d at 595.

151. *Id.* at 508, 196 N.E.2d at 598.

152. *See* note 119 *supra* and accompanying text.

ordinary and common knowledge of lay jurors. In *Hundemer v. Sisters of Charity*[153] the court considered a claim that resulted from the infiltration of the drug Levophed into the tissues surrounding the plaintiff's veins. The court in *Hundemer* distinguished *Jones* and concluded that expert testimony was necessary to determine if the drug had been administered incorrectly. The court's unstated distinction seems to center on the conclusion that although unattended falls may be within the scope of an ordinary juror's knowledge, administration of drugs is not.

A more difficult case is *Johnson v. Grant Hospital.*[154] In *Johnson* a nurse allegedly did not lock a mentally ill patient's room, and the patient left the room and jumped from the hospital roof, committing suicide. The attending physician had left orders that the patient's room was to be locked at night. The court concluded that expert testimony was not necessary in this case, that even if it were, expert testimony existed in the record, and that a directed verdict for the defendant was inappropriate since a genuine issue of fact existed. In reaching these conclusions the court constructed a two-tier approach to determine whether expert witnesses are needed in nursing malpractice actions. In so doing, the court recognized that this requirement varies depending on the nursing act at issue. The court noted:

> [e]ven though specially trained, a nurse must also exercise the standard of care of an ordinary prudent person. Where the issue is one of an exercise of judgment or skill requiring the specialized training of a nurse, expert opinion would be required.[155]

Acceptance of this rule, however, does not resolve all controversy. For example, in *Johnson* the majority appeared willing to conclude that expert testimony was not necessary in evaluating the question whether the patient had received adequate attention, yet the dissent concluded that expert testimony was necessary.[156]

Finally, in *Cramer v. Theda Clark Memorial Hospital,*[157] the Wisconsin Supreme Court also distinguished between acts requiring expert testimony and those acts that did not require expert testimony. In *Cramer* a post-operative patient broke his hip after a nurse had lowered the bed restraints in order that the patient could feed

153. 22 Ohio App. 2d 119, 258 N.E.2d 611 (1969).

154. 31 Ohio App. 2d 118, 286 N.E.2d 308 (1972).

155. *Id.* at 123, 286 N.E.2d at 313.

156. *Id.* at 127, 286 N.E.2d at 317. Further, the dissent questioned the factual conclusion of the court in *Jones* that an ordinary juror could determine negligence without the aid of expert testimony.

157. 45 Wis. 2d 147, 172 N.W.2d 427 (1969).

himself. The court cited *Jones* with approval and concluded that it was unnecessary to have expert testimony on the need to have the patient restrained.

The rule that evolves from the above cases is one of limited recognition of the need for expert testimony in nursing malpractice cases, the focus being on the nature of the act in question. The more technical the act *(e.g.,* drug administration), the more likely that expert testimony will be required. This may be an appropriate consideration, but the better approach would be to determine, as suggested by McCoid and the court in *Johnson,* whether the act required the exercise of judgment or specialized skill. Thus in *Cramer* the nurse might well be able to demonstrate that she loosened the restraints for the patient to feed himself because it was psychologically necessary, in her judgment, for the patient to begin to assume some control over his own care. This might have been an incorrect judgment. Nevertheless, if the nurse can show a nursing rationale for the act in question, expert testimony to evaluate that act should be required.

Once it is determined that an expert witness is required, the next question is who should qualify as an expert. *Hiatt v. Groce,*[158] a recent Kansas case, is a vehicle for considering this question. In *Hiatt* the court considered whether a nurse attending a woman during childbirth was negligent in failing to notify the attending physician of the impending delivery of plaintiff's baby. At trial the court found for the plaintiff in spite of expert testimony of a nurse and physician that, on the basis of hospital records, the nurse's action comported with sound nursing care. The supreme court upheld this judgment on the basis of the underlying facts of the case.[159] The trial court issued the following instruction to the jury on the question of the appropriate standard of care required of a nurse:

> In determining whether a registered nurse used the learning, skill and conduct required of her, you are not permitted to arbitrarily set a standard of your own or determine this question from your personal knowledge. On questions of nursing expertise concerning the standard of care of a nurse, only those qualified as experts are permitted to testify. The standard of care is established hy members of the same profession in the same or similar communities under like circumstances.[160]

158. 215 Kan. 14, 523 P.2d 320 (1974).

159. There was testimony at trial that on the night in question the nurse and the plaintiff had argued about the nurse's alleged lack of concern about the plaintiff's condition. In addition, while the nurse in fact delivered the baby, the hospital records indicated that a physician had delivered the baby. Since the experts had relied on the hospital records, the demonstrated inaccuracy of the records undermined the value of the expert testimony. 215 Kan. at 20-21, 523 P.2d at 326-27.

160. *Id.* at 19, 523 P.2d at 325.

In spite of this instruction, particularly its requirement of experts from the same profession as the defendant, the trial court allowed a physician to testify as an expert witness on the adequacy of nursing care provided the plaintiff. In addition, one professor of maternity nursing also testified concerning the quality of nursing care.[161]

Despite the court's failure to adhere to its own standard, its instruction is a sound statement of what the law should be. The use of physician testimony is, however, common practice.

The confusion apparently results from the fact that nursing and medicine have an overlapping knowledge base because both nurses and physicians study disease and treatment of disease. Thus both a coronary care specialist and a physician understand and can interpret various heart arrhythmias. This knowledge base, however, is overlapping, not coextensive. In the example above the physician and specialist nurse would know when and how to defibrallate a patient. The physician, in addition, could determine when surgery is necessary and could select the appropriate course of medical treatment *(e.g.,* drug selection). The nurse, on the other hand, would be able to select the appropriate intervention that would meet the patient's psychological needs, select and administer drugs according to established protocols in an emergency, plan for the patient's rehabilitation, and teach the patient self-care.[162]

One nursing commentator has suggested that in areas of shared expertise nurses could testify as expert witnesses in evaluating a physician's action.[163] Allowing a physician to testify in nursing malpractice actions or a nurse to testify in medical malpractice actions simply because they share common areas of knowledge unnecessarily confuses the issue. While either might be able to explain the action to the jury, liability is based on compliance with standards of practice of fellow professionals. Thus a nurse is being judged in comparison to other nurses, not physicians. Allowing individuals from another profession to testify tends to divert attention from evaluating the professional by compliance with his own professional standards. This distinction becomes critically important when a question of nursing judgment is being evaluated. Since liability is

161. *Id.*

162. This example is used for illustrative purposes only and is not intended to reflect or define the areas of competence of each profession.

163. The logical extension of allowing physicians to testify and to evaluate a nurse's action in those areas of shared expertise would be to allow nurses to testify as expert witnesses in an action against a physician in those same areas. Interview with Dr. Mauksch, *supra* note 37.

established by reference to what constitutes competent nursing behavior, physician testimony is irrelevant.[164] The physician can testify as to what a physician would do in the same situation, but that is not the question. The question is what a nurse should have done. Once it is recognized that nursing is a separate discipline and profession, it becomes clear that the key concern is how nurses have been trained to act. Only those who know how nurses have been trained to act can testify on that score. *Thompson v. United States*[165] supports this conclusion.

In *Thompson* the plaintiff, who complained of chest pain, was sent unattended to the laboratory for tests by a practical nurse.[166] The plaintiff fainted while standing in line and, as a result of the fall, had to have a finger amputated. At trial the plaintiff claimed that a nurse should be held to the same standard of care as a physician. The court rejected this contention and, in applying Louisiana law, decided that actions by nurses should be measured against standards of the nursing profession.[167] Thus *Thompson* recognized that there are differences in the medical and nursing professions and that competence in one profession does not necessarily indicate competence in the other profession. The court erred, however, in concluding that practical nurses should be judged by standards applicable to professional nurses. Practical nurses are licensed separately by the state[168] and have neither the educational background nor the legal authority to act in the same manner that registered nurses act. Several recent statutes also support the above reasoning and indicate that expert witnesses can come only from the defendant's profession. In both Arizona[169] and New Hampshire[170] new statutes provide that persons against whom malpractice claims are asserted should be measured against members of their own profession.

164. *Id.*

165. 368 F. Supp. 466 (W.D. La. 1973).

166. It should be noted that the defendant was not a registered nurse and therefore did not have the level of education or training that would qualify her for professional status. Thus while the discussion in the case is helpful for the general concepts developed, the analysis would be more satisfactory if it were limited to professional nurses. The court's apparent confusion and its implied suggestion that all nurses are the same reflects an understandable judicial confusion about the current status of nursing.

167. 368 F. Supp. at 468.

168. *See, e.g.*, LA. REV. STAT. ANN. tit. 37 § 961 (1974).

169. ARIZ. REV. STAT. § 12-563 (West Supp. 1977).

170. N.H. REV. STAT. ANN. § 508:13 (Supp. 1976).

C. *The Locality Standard Rule and the Significance of Educational Differences*

One of the most criticized of the special rules for malpractice actions is the so-called locality rule. The locality rule measures the actions of the professional practitioner against the standards of those practitioners practicing in the same or similar community rather than against a national standard of practice. Improvements in communication and standardization of educational requirements for entry into the profession have eroded the need and justification for a strict locality rule.[171] Thus many modern courts,[172] as well as some state legislatures,[173] have rejected it. Those states that still follow the locality rule in other professional and malpractice cases tend to use the rule for nursing malpractice actions as well. In the leading Louisiana case of *Norton v. Argonaut,*[174] a nurse was found liable for the death of an infant after she administered a drug to the child with a needle instead of administering the drug orally. In affirming the finding of liability the appellate court evaluated the nurse's actions by comparing them to nurses practicing in the same or similar communities.[175] Subsequent Louisiana cases have continued to use the locality standard in nursing malpractice actions.[176]

With the promulgation of standards of practice applicable to all nurses,[177] there is little justification for retention of the locality rule in nursing malpractice actions. The profession recognizes minimum levels of performance applicable to all nurses regardless of where the nurse is practicing. These standards are designed both to specify minimum levels of acceptable performance and to give the consumer a tool with which to evaluate the quality of nursing care he receives.[178] Retention of a locality rule would defeat both these goals. Whatever additional protection the locality rule is designed to give to professionals is not necessary since the professionals themselves desire to be judged by universal standards. Since there is little justification in retaining the locality rule in nursing malpractice

171. PROSSER, *supra* note 134, at 164.

172. *See, e.g.,* Landeros v. Flood, 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976); Speed v. State, 240 N.W.2d 901 (Iowa 1976).

173. N.H. REV. STAT. ANN. § 108:13 (1974).

174. 144 So. 2d 249 (La. App. 1962).

175. *Id.* at 251.

176. Samuels v. Doctor's Hospital, Inc., 414 F. Supp. 1124 (W.D. La. 1975); Thompson v. United States, 368 F. Supp. 466 (W.D. La. 1973); Thompson v. Brent, 245 So. 2d 751 (La. App. 1971).

177. *See* notes 44-55 *supra* and accompanying text.

178. *See* notes 41-42 *supra* and accompanying text.

cases, it is necessary to determine which standards of practice should be selected and used.

Until recently courts seldom evaluated the quality of care provided by a nurse in reference to the nurse's educational background. Since nurses enter the profession through one of three different educational programs and since the programs are not designed to provide the same training,[179] such an analysis seems appropriate in determining negligence. One case, *Hill v. Leigh Memorial Hospital,*[180] suggests that courts might be willing to consider such an argument if it were presented. The plaintiff in *Hill* fell from a bed that was not equipped with side rails and fractured her arm. Unlike plaintiffs in similar fall cases,[181] the plaintiff in this case apparently failed to produce evidence that her condition was such as to alert any health care provider of the need for special restraints or observation; thus the plaintiff was denied relief. The court noted that in addition to providing insufficient evidence of her condition the plaintiff also failed to show

> [w]hat kind of nurses these defendants were—whether registered nurses, practical nurses, student nurses or nurses aides and, hence, what degree of care would be imposed upon them in the performance of their duties.[182]

The clear implication of the above quotation is that a nurse's training and education should be considered in determining the amount of care the nurse owes to his or her patient.

Although the above language deals with professional and nonprofessional nurses, the rationale is equally applicable to the three classes of professional nurses. Once the proposition is accepted that education is a factor in the negligence standard to be used, a court must evaluate each nurse's training in order to determine if he or she has breached any duty owed to the patient. Thus, since associate degree nurses are trained to perform routinized tasks,[183] failure to exercise independent judgment on the part of such a nurse should not violate any duty owed to any patient. The same patient could reasonably expect a different form of care, however, if treated by a baccalaureate or more highly educated nurse.[184] Courts therefore should evaluate the educational background of professional nurses in determining whether the nurse breached a duty owed to the claimant.

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179. *See* notes 71-92 *supra* and accompanying text.
180. 204 Va. 501, 132 S.E.2d 411 (1963).
181. *See* notes 147 & 154 *supra* and accompanying text.
182. 204 Va. at 506, 132 S.E.2d at 416.
183. *See* note 87 *supra* and accompanying text.
184. *See* note 88 *supra* and accompanying text.

D. *Captain of the Ship Doctrine*

Another legal doctrine that has contributed to the delayed recognition of the professional status of nurses is the "captain of the ship" doctrine. This doctrine is usually applied to surgery and holds the surgeon in charge of the operation responsible for the acts of all those who work with him during the operation.[185]

The early case of *Beadles v. Metakya*[186] demonstrates the application of this doctrine and suggests proper limitations on its use. In *Beadles* the surgeon in charge gave conflicting instructions to an orderly who carried the instructions out without considering the result of such actions on the patient. The surgeon was held responsible for the resulting harm. Two factors in *Beadles* should be stressed. First, the surgeon gave specific instructions to the orderly, and it was these conflicting instructions that led to the patient's injury. Secondly, the instructions were given to a non-professional who did not have an independent base of professional knowledge to use in administering care to the patient. Thus the physician's liability appears appropriately established.

A much more difficult problem is confronted with the modern surgical team. These teams, in performing increasingly complex surgical procedures, are composed of several different professionals who each must apply his own professional skill if the procedure is to be successful. While each professional member of the team is working toward a common end result, the lead surgeon has neither the time nor expertise to direct specifically the performance of each person's assigned task. Perforce he must rely on each team member. In this situation the justification of one-man control and hence liability is increasingly difficult to justify.[187]

Several recent cases reflect the movement away from the captain of the ship doctrine as applied to nurses. In *Miller v. Hood*[188] a mid-level Texas court refused to hold a physician responsible for injuries caused when a nurse incorrectly administered an injection to a patient. The court, noting that this was not an operating room situation, held that in the absence of the controlled circumstances

185. S. WILLIG, THE NURSES GUIDE TO THE LAW 59 (1970).

186. 135 Colo. 366, 311 P.2d 711 (1957).

187. I. MURCHISON & T. NICHOLS, LEGAL FOUNDATION OF NURSING PRACTICE 245 (1970).

188. 536 S.W.2d 278 (Tex. Civ. App. 1976). Texas courts do, however, apply the captain of the ship doctrine in operating room cases. In Ramone v. Mani, 535 S.W.2d 654 (Tex. Civ. App. 1975), the court restated the Texas rule that "an operating surgeon may be held liable for the negligence of an assisting nurse in the general employment of the hospital when the alleged acts of negligence are done while the nurse is under the direct control or supervision of the surgeon." *Id.* at 655.

of the operating room, the physician is not responsible when a treatment he has ordered for a patient is incorrectly administered by a nurse. The case thus recognizes that the captain of the ship doctrine is limited to operating room cases. Additionally, the case impliedly recognizes the independent professional nature of nursing outside the operating room. Under this view nurses will be liable for their own actions and errors.

Although the captain of the ship doctrine retains vitality, two recent cases suggest that courts are reconsidering its applicability to modern medical situations. In *Sesselman v. Muhlenberg,*[189] the appellate court reversed a trial court verdict in favor of a malpractice claimant. The plaintiff claimed she suffered teeth and mouth injuries as a result of the incorrect administration of anesthesia by a nurse anesthetist during childbirth. At trial the claimant offered the testimony of a physician expert witness who claimed that a physician is responsible for anything that goes wrong in the operating room. The court noted that the nurse anesthetist was an employee of the hospital and that the record did not indicate that the surgeon attempted to control the manner in which she carried out her professional duties. The court thus concluded that the physician was not responsible for injuries that resulted from the anesthetist's actions.[190]

Parker v. St. Paul Fire & Marine Insurance Co.[191] is another recent case refusing to apply the captain of the ship doctrine to all operating room accidents. In *Parker,* the plaintiff was undergoing an emergency hysterectomy following the birth of her third child. During surgery, additional transfusions of blood were necessary. The operating room nurse took two units of blood for another patient and administered it to the plaintiff. The blood was incorrectly matched, was tagged with another patient's name and room number, but was nonetheless administered by the nurse to the plaintiff. Following the surgery, the plaintiff claimed to suffer from numerous postoperative problems caused by the incorrect transfusion. The court refused to hold the surgeon liable for the negligence of the nurse, finding that the nurse was not under the direct control of the surgeon.[192] This finding restricts the captain of the ship doctrine to very limited situations in which the nurse is responding to a direct order of the surgeon. When the nurse is carrying out tasks necessary for

189. 124 N.J. Super. 285, 306 A.2d 474 (Super. Ct. App. Div. 1973).
190. *Id.* at 290, 306 A.2d at 476.
191. 335 So. 2d 725 (La. App. 1976).
192. *Id.* at 734-35.

the operation but the surgeon is relying on the nurse to perform those tasks on the basis of her own professional skill, the surgeon is relieved of liability.

These recent cases, particularly *Parker,* correctly limit the captain of the ship doctrine. When a surgical team member responds to a direct order of the lead surgeon, it is proper to impose liability on that surgeon since he is coordinating the efforts of all team members. On the other hand, when the various tasks of a complex surgical procedure are divided among team members, the other professionals, including professional nurses, should be independently liable for their actions.

III. Nursing Malpractice Law—Suggestions for the Future

A. Determination of Liability—the Use of Nursing Standards of Practice

Both the legal community and the health care consumer appear unaware of the changes in nursing and the potential legal implications of these changes. The increasingly independent basis of nursing practice,[193] the promulgation of nationwide standards of practice,[194] the identification of different nursing roles based on educational preparation,[195] and the movement toward a certification program[196] have all gone practically unnoticed. Thus the public expects too little from nurses because it knows too little about them. The case law demonstrates that most courts view nursing in its traditional dependent role and thus impose liability only in cases involving falls,[197] failure to carry out a physician's orders,[198] and neglect of a patient.[199] Furthermore, the courts require the same conduct from all nurses even though all nurses do not have the same skills. The following suggestions offer a framework for the development of a rational and reasonable method of evaluating the quality of nursing care.

To determine whether a nurse should be held liable for malpractice, three questions must be asked: First, what is the nature of the act complained of? Secondly, what are the qualifications of the nurse who performed the act? Thirdly, where was the care

193. *See* note 31 *supra* and accompanying text.
194. *See* notes 44-55 *supra* and accompanying text.
195. *See* notes 77-92 *supra* and accompanying text.
196. *See* notes 56-70 *supra* and accompanying text.
197. *See* note 157 *supra* and accompanying text.
198. *See* note 154 *supra* and accompanying text.
199. *See* notes 123 & 158 *supra* and accompanying text.

provided? In considering the first question, a court should look to the national standards of practice. Licensure indicates that all nurses do share a common core of knowledge and establishes a minimum level of competence, but state licensure statutes are usually too general to be of use in evaluating a specific nursing act.[200] The national standards of practice, however, do build on the idea of licensure and provide a useful device for evaluating the nursing act in question. The national standards, like the state licensure laws, recognize that all nurses must meet certain minimum levels of performance and the standards detail those minimum levels. As previously described, the nursing standards are twofold—generic and specialty.[201] The generic standards apply to all nurses and the specialty standards, which expand on the generic standards, describe minimum acceptable levels of performance in various specialty areas. The courts should review both the generic standards and the applicable specialty standards to determine if any standard has been breached. If the nurse's act violates either generic or specialty standards, a prima facie showing of liability is established.

The standards developed by the American Nurses Association[202] could be applied in the following manner. If the nurse failed to chart fluid and electrolyte balance, for example, and the patient was harmed because this information was not collected, charted, or communicated to other health care providers, the nurse would be subject to liability.[203] Thus, to determine liability, the court should break down the harmful act into its component parts. It should study nursing standards, along with their relevant assessment factors, to determine whether the nurse's act was one within that nurse's area of responsibility and, if so, whether the nurse failed to perform the act according to those standards. If so, it would be necessary to determine if the nurse's improper act caused the pa-

200. Most licensure acts broadly define the scope of permissible practice and do not indicate the degree of skill that should be used in performing a specific task or even a group of tasks. *See* note 31 *supra* and accompanying text.

201. *See* note 47 *supra* and accompanying text.

202. *See* note 53 *supra* and accompanying text.

203. The concept of negligence per se for violation of a statute is an appropriate analogy. Jurisdictions have adopted one of three approaches when a violation of a statute is shown. Many jurisdictions find such a violation conclusive on the issue of negligence; a second group of jurisdictions find the violation only some indication of negligence, while a third group of jurisdictions conclude that the violation creates a rebuttable presumption of negligence. For this note the third approach is the most desirable. Once a plaintiff shows a failure on the part of a nurse to comply with a standard of practice the burden of proof switches to the nurse to rebut the presumption of negligence. If the nurse is not able to rebut the presumption, the judge should issue a binding instruction on the subject to the jury. *See* PROSSER, *supra* note 134, at 201.

tient's harm. The NAACOG standards could be used in the same way.[204] For instance, if any nurse other than a specially qualified nurse attempted to remove sutures or a vaginal packing and the patient was harmed by these acts, a clear breach of duty would be established.

Use of the standards will require the use of nurses as expert witnesses. If liability is to attach because the nurse failed to conform to the expected standards of nursing practice, then only nurses should be competent to testify about the applicable standard, about the nursing implications of the act in question, and about the alleged failure of the nursing act to conform to the applicable nursing standard. A physician's expertise in medical practice should not qualify him as an expert in evaluating nursing practice; therefore the common practice of allowing physicians to testify as expert witnesses on the quality of nursing care[205] is inappropriate if liability is established by showing a violation of a nursing standard.

The second question required to formulate the appropriate standard of care focuses on the nurse's educational background. This second factor should be combined with the first in the following fashion: deviation from a standard of practice would establish liability for all nurses, but a nurse with more expertise would be expected to conduct her actions in accordance with that level of expertise. For the purposes of the following discussion, the term "technical nurse" will apply to all non-baccalaureate degree nurses and the term "professional nurse" shall apply to all nurses with a baccalaureate or higher degree in nursing. Recognition of the educational differences among nurses will result in greater exposure to liability for professional nurses since they have the background and ability to assume independent roles in the expansion of nursing practice.[206] The discussion of the educational programs above supports this conclusion.[207] The professional nurse will function in three settings and the technical nurse primarily in one setting. Technical nurses will be found on general care floors of hospitals while professional nurses will be found outside of hospitals, in specialty areas within hospitals, and on general care floors of hospitals.

The professional nurse treats clients on a one-to-one basis outside the hospital, evaluates symptoms, and refers clients to other

204. *See* notes 54-55 *supra* and accompanying text.
205. *See* note 161 *supra* and accompanying text.
206. *See* note 89 *supra* and accompanying text.
207. *See* notes 78-93 *supra* and accompanying text.

health care providers and direct services that prevent diseases.[208] In the hospital the professional nurse directs the general nursing care for the patient or provides specialty care for the patient. Technical nurses, on the other hand, perform basic care for patients under the supervision of a professional nurse or other health care provider.[209] Thus, while it is possible, indeed likely, to find both technical and professional nurses in the same setting, the law should not require them to react identically to the same medical problem. Failure of the technical nurse to exercise independent judgment in a given situation would not establish liability since that nurse would not be expected to act independently. In fact, independent action might result in liability. In contrast, the same failure to exercise independent judgment on the part of a professional nurse could well establish liability.[210] A relatively recent development, the clinical nurse specialist, offers another example of why a flexible standard of care based on educational background is necessary. The clinical nurse specialist has at least a master's degree in a clinical area of nursing practice. With this advanced preparation the nurse has the ability to act in an even more independent manner than would the nurse with only a baccalaurate degree. It would be completely unrealistic to hold the nurse specialist only to the level of performance expected from a technical nurse.

Differentiation of a standard of care based on educational preparation has one additional component. In order to prove deviance from a professional norm, the expert witness will have to have an educational background at least equal to that of the nurse whose act is subject to review. Thus, if liability is to be established in an independent area of practice, a technical nurse would not be competent to testify on whether a professional nurse acted in accord with professional norms.

In summary, all nurses must act in accordance with the national standards of practice. A court focusing on a nurse's allegedly negligent act, must determine if the act called for a dependent

208. SREB, *supra* note 83, at 9.

209. *See* note 87 *supra* and accompanying text.

210. It is necessary to distinguish two bases of liability—failing to exercise professional judgment in the first instance and exercising faulty professional judgment. This discussion focuses primarily on the duty of the professional nurse to exercise her professional judgment. It is that failure that suggests liability. Determining liability if the nurse does exercise professional judgment but does so in a faulty manner should be subject to the "school of thought" exception that recognizes that there may be different schools of thought on how to treat a particular disease and that if a professional follows one of these schools of thought liability cannot attach simply because other professionals would have followed other schools of thought. *See* PROSSER, *supra* note 134, at 163.

response or an independent judgment. If independent action was called for, the educational background of the nurse must be considered in order to determine if the act was unreasonable. Nursing science has progressed to the point that nursing experts can evaluate the professional nurse's act and determine if that act meets acceptable nursing standards.

The third consideration, the setting in which the care is provided, has been alluded to above. Certain institutions, particularly hospitals, will use graduates from different programs with different skills.[211] This should not present serious analytical difficulty, however, since these institutions are designed to provide a wide range of services. The hospital should be designed and staffed so that nurses' skills are effectively utilized. For instance, those patients who require hospitalization but whose illnesses are well defined and predictable can be cared for adequately by technical nurses.[212] On the other hand, there will be patients whose illnesses either are undefined or unpredictable. Individuals in critical care or specialty units might be in this category. Those patients require closer attention and their conditions might change dramatically in a very short period of time, requiring quick and accurate response by the attending nurse. Since the professional nurse has the education to respond to such situations,[213] they should be utilized in this area.

Individuals in a hospital, therefore, will receive different nursing care depending on their condition. The classification system described above, while idealized, does provide for a cost-effective delivery of health care. At first it may seem inequitable since some patients (those most critically or unpredictably ill) will receive different nursing care than other patients in the same institution at the same time. This apparent inequity is justified and indeed consonant with current medical practice. Traditionally, those individuals deemed most ill have received the most attention. This description projects the delivery of nursing care into the current system to ensure that those individuals most in need of independent nursing care receive that care.

Although the above discussion has focused on nursing care in an institutional setting, nurses are currently practicing in many different areas. A recent development has included nurses going into private practice.[214] While professional nurses are prepared to assume

211. *See* notes 76-92 *supra* and accompanying text.
212. *See* notes 82 & 87 *supra* and accompanying text.
213. *See* note 88 *supra* and accompanying text.
214. Alford & Jensen, *Reflections on Private Practice,* 76 AM. J. NURSING 1966 (1976).

this role with some additional training,[215] the current experience indicates that most frequently it is nurses with master's degrees or higher who are in private practice.

With the three elements outlined above, it is now possible to describe a framework for determining how a possible nursing malpractice problem should be approached. If the act in question occurred in a hospital, it is necessary to determine if the patient was provided with appropriate nursing care. This involves a review of the classification of the patient. If the patient was receiving routinized care because the illness indicated such care was appropriate, then technical nursing practice would be the appropriate measure of whether adequate care was theoretically provided. If, however, the patient needed professional nursing care and was provided only with technical nursing care, the institution might be liable for failing to provide that greater care.

If the patient was provided initially with the appropriate level of nursing care, the inquiry should focus on the nurse and the act in question. At this point the nurse's educational background would suggest the degree of skill expected of the nurse. The various professional standards would indicate whether the act in question met, or failed to meet, minimal standards of professional performance. Expert witnesses would evaluate the act in terms of these standards and in terms of the educational preparation of the nurse.

If the nurse is in private practice, the initial inquiry is virtually unnecessary. There is no need to determine if the plaintiff was appropriately classified since the plaintiff will have selected the nurse to provide the care in question. Instead, attention will focus on whether the individual nurse had the education and experience to practice independently and, if so, whether the nurse was negligent in providing the care that is being questioned.

B. Determination of Liability—Certification

Although presently in a confused state, certification eventually will be another significant factor in determining the appropriate standard of care for a nurse. Certification of a nurse will evidence that he or she has attained a higher level of achievement than noncertified nurses. This, in turn, will justify imposing a higher standard of care on the certified nurse. Currently, however, of all the potential factors considered in formulating the appropriate standard of care, certification is the most difficult to analyze and apply.

215. *See* note 89 *supra* and accompanying text.

The reasons for this difficulty are threefold. First, the considerable controversy surrounding the current certification program has weakened its credibility. Several groups of nurses have opposed or refrained from supporting the nurse certification program.[216] As long as this dissension continues it will be difficult to claim with any authority that certification signifies the profession's recognition of competence. Secondly, because of the changes in the certification program, the meaning of certification is likely to remain unclear. If all nurses are competent to sit for certification examinations, the educational distinctions described above will have much less force.[217] This conceptual difficulty appears to be behind the recent move for a bifurcated certification program. Thirdly, the actual status of the program is in doubt.[218] Because the certification program is costly to administer, testing in some specialties has been suspended. Until the above difficulties are resolved, certification should not be a significant factor in determining the appropriate standard of care.

C. Implications of a Higher Standard of Care

Adoption of the suggestions above will result in nurses being held to a higher standard of care and will result in increased malpractice judgments against nurses. With the hue and cry about increasing numbers of medical malpractice actions, can such a result be justified? Not only can the result be justified, it also can produce benefits for nurses themselves.

One of the major reasons that nursing has received inadequate attention is the public's lack of understanding about what it should expect from nurses. The adoption by nursing organizations of standards of practice and the development of an analytical framework for differentiating what nurses from different backgrounds are pre-

216. *See* notes 65-66 *supra* and accompanying text.

217. The implication of a single certification program for excellence in an area of nursing will necessarily undermine the very real differences in educational programs. If anyone can attain excellence, then there is no justification in allowing three different programs to produce nurses at various costs to the individual student. If the differences can be compensated for by experience, then the implication is that all nurses with equal experience, regardless of backgrounds, are able to perform the same tasks. Since the research into the various educational programs suggests that there are real differences in the type of education received, a single certification program seems to be the result of an attempted compromise between the more numerous non-baccalaureate nurses and the baccalaureate nurses. The underlying compromise may well be that the certification program will appear to be open to all nurses, but in reality non-baccalaureate nurses will have a significantly more difficult time in becoming certified than baccalaureate nurses.

218. *See* note 69 *supra* and accompanying text.

pared to do could largely eliminate the source of this confusion. A more realistic standard of care becomes an absolute necessity as nurses assume independent roles. As the independent roles become understood and utilized, nurses should be held accountable for their actions. The development of professional standards provides a ready reference for measuring a nurse's performance. In addition, use of these standards extends to nursing the privilege of determining what is and what is not satisfactory performance.

Utilization of these standards can be justified on two grounds. First, the increased educational level of nurses indicates a growing sophistication of knowledge that allows nurses to function in an independent manner. With the increase of health care costs and with nurses offering an alternative to total physician delivery of health care that can lower these costs, the public benefits from nursing's ability to assume a more responsible role in health care. With this more responsible role it seems appropriate to recognize the underlying expertise of the nursing profession and to allow the profession to use its expertise to determine what is satisfactory nursing behavior.

The concern with allowing any profession to set its own standards is that the profession will act in a manner of self-interest and the individual consumer will thereby be harmed. It is precisely this concern, however, that provides the second justification for allowing nursing to set its own standards. The nursing profession has been quick to recognize the needs of the health care consumer. Nursing has moved to include lay representatives on its various state boards of nursing,[219] has stressed the right of the consumer to participate and control decisions about his own care, and has adopted and published national standards of practice that consumers can use in measuring the quality of nursing care received. All of these factors reflect a keen sensitivity to public needs and suggest that the nursing profession is ready to live up to the responsibility that accompanies the privilege of helping to define the appropriate standard of liability. By permitting nursing to establish the appropriate standard of liability, the trend toward more independent nursing action will be reinforced.

Allowing the nursing profession the right to define its own standard of liability will produce a further result. If nurses are hospital employees, the hospital will be liable for acts of nursing malpractice under the concept of respondeat superior. Once hospitals recognize

219. *See, e.g.*, NEV. REV. STAT. § 632.020 (1973).

that their potential liability has expanded and that nursing standards are one of the major sources for defining the extent of potential liability, the hospitals will, out of economic self-interest, accord nurses a greater say in the allocation of resources in order to limit their potential exposure.

In allocating resources, rationally run institutions will ensure that perceived critical needs are met before considering less critical needs. Currently, since nurses are held to a low standard of care, there is no great external pressure on hospitals to upgrade this care. If hospitals faced significant financial liability because they provide either insufficient numbers of nurses or inadequate nursing care, there would be reasons to upgrade nursing care. If liability attached because nursing standards established by nurses were violated, hospitals by necessity would have to consult with nurses in order to ensure that they provide satisfactory nursing care. Further, if nursing standards indicated that with x number of patients there must be y number of nurses and certain kinds of patients required professional nursing care, hospitals would be under pressure to ensure that floors were not understaffed and that professional nursing care was available. This will not only give nurses more power and status in the health care system, but also will enable them to lobby for changes that will benefit the health care consumer.

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